Complete Summary

GUIDELINE TITLE

Practice guidelines for postanesthetic care: a report by the American Society of Anesthesiologists Task Force on Postanesthetic Care.

BIBLIOGRAPHIC SOURCE(S)

American Society of Anesthesiologists Task Force on Postanesthetic Care. Practice guidelines for postanesthetic care: a report by the American Society of Anesthesiologists Task Force on Postanesthetic Care. Anesthesiology 2002 Mar;96(3):742-52. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Conditions requiring anesthesia

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Anesthesiology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To improve postanesthetic quality of life, reduce postoperative adverse events, provide a uniform assessment of recovery, and streamline postoperative care and discharge criteria
- To evaluate available evidence and provide recommendations for patient assessment, monitoring, and management with the goal of optimizing patient safety

TARGET POPULATION

Patients of all ages who have just received general anesthesia, regional anesthesia, or moderate or deep sedation

Note: The Guidelines may need to be modified to meet the needs of certain patient populations, such as children or the elderly.

The Guidelines do not apply to patients receiving infiltration local anesthesia without sedation, patients receiving minimal sedation (anxiolysis), or patients receiving intensive care.

INTERVENTIONS AND PRACTICES CONSIDERED

Patient Assessment and Monitoring

1. Respiratory function assessment
    - Respiratory rate
    - Oxygen saturation [SpO2]
    - Airway patency
2. Cardiovascular assessment
    - Blood pressure
    - Pulse rate
    - Electrocardiogram (in selected patients)
3. Assessment of neuromuscular function
    - Physical examination
    - Monitoring of neuromuscular blockade (in selected patients)
4. Mental status assessment
5. Temperature assessment
6. Pain assessment
7. Nausea and vomiting assessment
8. Fluid assessment (hydration status) and management
9. Assessment of urine output and voiding (in selected patients)
10. Assessment of draining and bleeding

Treatment During Emergence and Recovery

1. Prophylaxis and treatment of nausea and vomiting with antiemetic agents (5-HT3 antagonists, droperidol, dexamethasone, or metoclopramide)
2. Supplemental oxygen (for patients at risk of hypoxemia)

3. Normalization patient temperature (forced-air warming systems)
4. Pharmacologic agents for the reduction of shivering (meperidine)
5. Antagonism of the effects of sedatives, analgesics, and neuromuscular block (if indicated)
    - Antagonism of benzodiazepines (flumazenil)
    - Antagonism of opioids (naloxone)
    - Reversal of neuromuscular blockade (neostigmine, edrophonium)

Protocol for Discharge from Postanesthesia Care Unit

1. Predischarge criteria requirements
    - Requiring that patients urinate before discharge (not routinely recommended)
    - Requiring that patients drink clear fluids without vomiting before discharge (not routinely recommended)
    - Mandatory minimum stay in recovery (not recommended)
    - Ensuring that responsible individual is available to accompany patient home
2. Provision of written instructions for patients and carers

MAJOR OUTCOMES CONSIDERED

- Postanesthetic adverse events (e.g., respiratory and cardiovascular complications, nausea/vomiting, shivering, hypothermia)
- Patient comfort and satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Scientific evidence was derived from aggregated research literature and from surveys, open presentations, and other consensus-oriented activities. For purposes of literature aggregation, potentially relevant clinical studies were identified via electronic and manual searches of the literature. The electronic search covered a 36-year period from 1966 through 2001. The manual search covered a 53-year period from 1949 through 2001. More than 3,000 citations were initially identified, yielding a total of 1,027 nonoverlapping articles that addressed topics related to the 23 evidence linkages. After review of the articles, 490 studies did not provide direct evidence and were subsequently eliminated. A total of 537 articles contained direct linkage-related evidence.

NUMBER OF SOURCE DOCUMENTS

A total of 537 articles contained direct linkage-related evidence.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The following terms describe the strength of scientific data obtained from the scientific literature:

Supportive: There is sufficient quantitative information from adequately designed studies to describe a statistically significant relationship ($P<0.01$) between a clinical intervention and a clinical outcome, using meta-analysis.

Suggestive: There is sufficient information from case reports and descriptive studies to provide a directional assessment of the relationship between a clinical intervention and a clinical outcome. This type of qualitative information does not permit a statistical assessment of significance.

Equivocal: Qualitative data have not provided a clear direction for clinical outcomes related to a clinical intervention and (1) there is insufficient quantitative information or (2) aggregated comparative studies have found no quantitatively significant differences among groups or conditions.

The following terms describe the lack of available scientific evidence in the literature:

Inconclusive: Published studies are available, but they cannot be used to assess the relationship between a clinical intervention and a clinical outcome because the studies either do not meet predefined criteria for content as defined in the "Focus of the Guidelines" or do not provide a clear causal interpretation of findings due to research design or analytic concerns.

Insufficient: There are too few published studies to investigate a relation between a clinical intervention and a clinical outcome.

Silent: No studies that address a relationship of interest were found in the available published literature.

The following terms describe survey responses for any specified issue. Responses are assigned a numeric value of agree = +1, undecided = 0, or disagree = -1. The average weighted response represents the mean value for each survey item.

Agree: The average weighted response must be equal to or greater than +0.30 (on a scale of -1 to 1) to indicate agreement.

Equivocal: The average weighted response must be between -0.30 and +0.30 (on a scale of -1 to 1) to indicate an equivocal response.

Disagree: The average weighted response must be equal to or less than -0.30 (on a scale of -1 to 1) to indicate disagreement.

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

A directional result for each study was initially determined by a literature count, classifying each outcome as supporting an evidence linkage, refuting a linkage, or neutral. (Note: These linkages represent directional statements about relationships between perioperative care and postanesthetic clinical outcomes.) The results were then summarized to obtain a directional assessment of support for each linkage. Literature pertaining to seven evidence linkages contained enough studies with well-defined experimental designs and statistical information to conduct formal meta-analyses. These seven linkages were as follows: linkage 11 (prophylaxis of nausea and vomiting), linkage 12 (treatment of nausea and vomiting), linkage 13 (multiple medications for the prophylaxis of nausea and vomiting), linkage 15 (supplemental oxygen), linkage 17 (forced-air warming systems), linkage 18 (meperidine for shivering), and linkage 19 (reversal agents to antagonize the effects of sedatives, analgesics, or neuromuscular blocking agents).

Combined probability tests were applied to continuous data, and an odds-ratio procedure was applied to dichotomous study results. Two combined probability tests were used as follows: (1) the Fisher combined test, producing chi-square values based on logarithmic transformations of the reported p values from the independent studies, and (2) the Stouffer combined test, providing weighted representation of the studies by weighting each of the standard normal deviates by the size of the sample. An odds-ratio procedure based on the Mantel-Haenszel method for combining study results using 2 X 2 tables was used with outcome frequency information. An acceptable significance level was set at $P<0.01$ (one-tailed), and effect size estimates were calculated.

Tests for heterogeneity of the independent studies were conducted to assure consistency among the study results. DerSimonian-Laird random-effects odd ratios were calculated when significant heterogeneity was found. To control for potential publishing bias, a "fail-safe N" value was calculated for each combined probability test. No search for unpublished studies was conducted, and no reliability tests for locating research results were done.

Meta-analytic results are reported in table 5 of the original guideline document. To be considered acceptable findings of significance, both the Fisher and weighted Stouffer combined test results must agree. The following outcomes were found to be significant: (1) recovery time: linkage 19 (flumazenil to antagonize general anesthesia, flumazenil to antagonize sedation, edrophonium to antagonize neuromuscular blockade, and neostigmine to antagonize neuromuscular blockade); (2) temperature: linkage 17 (forced-air warming); and (3) time to discharge: linkage 11 (metoclopramide for prophylaxis of nausea and vomiting). Weighted effect size values for these linkages ranged from $r = 0.22$ to $r = 0.99$, representing moderate-to-large effect size estimates.

Odds ratios were significant for the following outcomes: (1) reduced nausea: linkage 11 (5-HT3 prophylaxis--granisetron and ondansetron, droperidol prophylaxis, metoclopramide prophylaxis, and dexamethasone prophylaxis) and linkage 13 (multiple medications prophylaxis); (2) reduced vomiting: linkage 11 (antihistamine prophylaxis, 5-HT3 prophylaxis--granisetron and ondansetron, droperidol prophylaxis, scopolamine prophylaxis, and dexamethasone prophylaxis), linkage 12 (ondansetron treatment), and linkage 13 (multiple medications prophylaxis); (3) increased vomiting: linkage 19 (neostigmine to antagonize neuromuscular blockade); (4) reduced headache: linkage 11 (droperidol prophylaxis); (5) increased agitation and restlessness: linkage 11 (droperidol prophylaxis); (6) increased drowsiness: linkage 11 (droperidol prophylaxis); (7) reduced hypoxemia: linkage 15 (supplemental oxygen); and (8) reduced shivering: linkage 17 (forced-air warming) and linkage 18 (meperidine). To be considered acceptable findings of significance, Mantel-Haenszel odds ratios must agree with combined test results when both types of data are assessed.

Agreement among Task Force members and two methodologists was established by interrater reliability testing. Agreement levels using a kappa statistic for two-rater agreement pairs were as follows: (1) type of study design, kappa = 0.80--1.00; (2) type of analysis, kappa = 0.55-1.00; (3) evidence linkage assignment, kappa = 0.91-1.00; and (4) literature inclusion for database, kappa = 0.78-1.00. Three-rater chance-corrected agreement values were as follows: (1) study design, Sav = 0.86, Var (Sav) = 0.011; (2) type of analysis, Sav = 0.65, Var (Sav) = 0.026; (3) linkage assignment, Sav = 0.81, Var (Sav) = 0.005; and (4) literature database inclusion, Sav = 0.84, Var (Sav) = 0.045. These values represent moderate to high levels of agreement.

The findings of the literature analyses were supplemented by the opinions of Task Force members as well as by surveys of the opinions of a panel of Consultants and a random sample of the American Society of Anesthesiologists (ASA) membership, as described in the text of the Guidelines. The rate of return was 50% (N = 56/112) for the Consultants and 21% (N = 211/1,000) for the membership. The percentage of Consultants and ASA members supporting each linkage is reported in table 6 of the original guideline document. Consultants and ASA members were supportive of all of the linkages, with the following exceptions: linkage 9 (routine assessment of urinary output and voiding), linkage 11 (routine pharmacologic prophylaxis of nausea and vomiting), linkage 12 (nonpharmacologic treatment of nausea and vomiting), linkage 15 (supplemental oxygen during transport or in the postanesthesia care unit), linkage 19 (routine use of flumazenil and naloxone), linkage 20 (requiring that patients urinate before discharge), linkage 21 (requiring that patients drink water before discharge), and linkage 23 (requiring a minimum stay in recovery).

The Consultants were asked to indicate which, if any, of the evidence linkages would change their clinical practices if the Guidelines were instituted. The rate of return was 35% (N = 39/112). The percent of responding Consultants expecting no change associated with each linkage were as follows: assessment and monitoring of respiratory function--100%; cardiovascular assessment/monitoring--95%; assessment of neuromuscular function--95%; assessment of mental status--97%; assessment of temperature--95%; assessment and monitoring of pain--100%; assessment of nausea and vomiting--97%; fluid assessment and management--100%; assessment and monitoring of urine output and voiding--

95%; assessment of draining and bleeding--100%; prophylaxis of nausea and vomiting--95%; treatment of nausea and vomiting--97%; multiple medications for the prophylaxis of nausea and vomiting--95%; multiple medications for the treatment of nausea and vomiting--97%; administration of supplemental oxygen--100%; normalizing patient temperature--100%; forced-air warming systems--85%; meperidine for shivering--92%; flumazenil for reversal of general anesthesia--95%; flumazenil for reversal of sedation--97%; naloxone for opioid reversal--100%; edrophonium for reversal of neuromuscular blockade--97%; neostigmine for reversal of neuromuscular blockade--100%; not requiring that patients urinate before discharge--92%; not requiring patients to drink water without vomiting before discharge--85%; requiring that patients have a responsible individual accompany them home--95%; and not requiring a mandatory minimum stay in recovery--85%. Eighty-two percent of the respondents indicated that the Guidelines would have no effect on the amount of time spent on a typical case.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The American Society of Anesthesiologists (ASA) appointed a Task Force of 10 members to review the published evidence and obtain consultant opinion from a representative body of anesthesiologists. The Task Force members consisted of anesthesiologists in both private and academic practices from various geographic areas of the United States, and methodologists from the ASA Committee on Practice Parameters.

The Task Force met its objective in a six-step process. First, original published research studies relevant to postanesthetic care were reviewed and analyzed. Second, Consultants with expertise in postanesthetic care and who practice or work in various settings (e.g., academic and private practice) were asked to (1) participate in opinion surveys and (2) review and comment on drafts of the Guidelines. Third, a random sample of active members of the ASA was surveyed regarding various elements of the Guidelines. Fourth, The Task Force held an open forum at a major national meeting to solicit input from attendees on the draft Guidelines. Fifth, all available information was used by the Task Force in developing the Guideline recommendations. Sixth, the Consultants were surveyed to assess their opinions on the feasibility and financial implications of implementing the Guidelines.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultants with expertise in postanesthetic care and who practice or work in various settings (e.g., academic and private practice) were asked to review and comment on drafts of the Guidelines.

A random sample of active members of the American Society of Anesthesiologists (ASA) was surveyed regarding various elements of the Guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Perioperative Patient Assessment and Monitoring

Perioperative and postanesthetic management of the patient includes periodic assessment and monitoring of respiratory and cardiovascular function, neuromuscular function, mental status, temperature, pain, nausea and vomiting, drainage and bleeding, and urine output (see table below titled "Summary of Recommendations for Assessment and Monitoring). Where specific monitoring is recommended, the duration of the intervention will be dependent upon the patient's clinical status. Specific criteria may be useful for clinical documentation.

Respiratory Function

Recommendations: Periodic assessment of airway patency, respiratory rate, and oxygen saturation (SpO_2) should be done during emergence and recovery. Particular attention should be given to monitoring oxygenation and ventilation. ("Standards for postanesthesia care," 1999)

Cardiovascular Function

Recommendations: Routine monitoring of pulse and blood pressure should be done during emergence and recovery, and electrocardiographic monitors should be immediately available.

Neuromuscular Function

Recommendations: Assessment of neuromuscular function should be performed during emergence and recovery for patients who have received nondepolarizing neuromuscular blocking agents or who have medical conditions associated with neuromuscular dysfunction.

Mental Status

Recommendations: Mental status should be periodically assessed during emergence and recovery.

Temperature

Recommendations: Patient temperature should be periodically assessed during emergence and recovery

Pain

Recommendations: Pain should be periodically assessed during emergence and recovery.

Nausea and Vomiting

Recommendations: Periodic assessment of nausea and vomiting should be performed routinely during emergence and recovery.

Fluids

Recommendations: Postoperative hydration status should be assessed in the postanesthesia care unit (PACU) and managed accordingly. Certain procedures involving significant loss of blood or fluids may require additional fluid management.

Urine Output and Voiding

Recommendations: Assessment of urine output and of urinary voiding should be done on a case-by-case basis for selected patients or selected procedures during emergence and recovery.

Drainage and Bleeding

Recommendations: Assessment of drainage and bleeding should be performed when indicated during emergence and recovery.

Summary of Recommendations for Assessment and Monitoring

Routine	Selected Patients
Respiratory Respiratory rate Airway patency Oxygen saturation	
Cardiovascular Pulse rate Blood pressure	Electrocardiogram
Neuromuscular	Neuromuscular blockade

Routine	Selected Patients
Physical examination	Nerve stimulator
Mental Status	
	Temperature
Pain	
Nausea and vomiting	
	Urine Voiding Output
	Drainage and Bleeding

Treatment During Emergence and Recovery

Prophylaxis and Treatment of Nausea and Vomiting

Recommendations: Antiemetic agents should be used for the prevention and treatment of nausea and vomiting when indicated. Multiple agents may be used for the prevention or treatment of nausea and vomiting when indicated (see table below titled "Summary of Treatment Recommendations").

Administration of Supplemental Oxygen

Recommendations: Administration of supplemental oxygen is effective in preventing and treating hypoxemia. Administering supplemental oxygen during transportation or in the recovery room should be done for patients at risk of hypoxemia.

Normalizing Patient Temperature

Recommendations: Normothermia should be a goal during emergence and recovery. When available, forced air warming systems should be used for treating hypothermia.

Pharmacologic Agents for the Reduction of Shivering

Recommendations: Meperidine should be used for the treatment of patient shivering during emergence and recovery when clinically indicated. The Task Force cautions that hypothermia, a common cause of shivering, should be treated by rewarming. Practitioners may consider other opioid agonists or agonist--antagonists when meperidine is contraindicated or not available.

Summary of Treatment Recommendations

Prophylaxis and treatment of nausea and vomiting
Antiemetic agents (i.e., 5-HT_3 antagonists, droperidol, dexamethasone, or metoclopramide) may be used for prophylaxis or treatment when indicated. Multiple agents may be used for prophylaxis or treatment when indicated.

Other antiemetics or nonpharmacologic agents may be used for treatment when indicated, although the evidence supporting their use is less robust.

Supplemental oxygen

Supplemental oxygen for patients at risk of hypoxemia is recommended.

Fluid administration and management

Postoperative fluids should be managed in the PACU
Certain procedures may require additional fluid management.

Normalizing patient temperature

Normothermia should be maintained.

Forced-air warming systems are most effective for treating hypothermia.

Pharmacologic agents for the reduction of shivering

Meperidine is recommended.

Antagonism of the effects of sedatives, analgesics, and neuromuscular block

Antagonism of benzodiazepines

Antagonists should be available.

Flumazenil should not be used routinely.

Flumazenil may be administered to antagonize respiratory depression and sedation.

After pharmacologic reversal, patients should be observed long enough to ensure that cardiorespiratory depression does not recur.

Antagonism of opioids

Antagonists (e.g., naloxone) should be available but should not be used routinely.

Naloxone may be administered to antagonize respiratory depression and sedation.

After pharmacologic reversal, patients should be observed long enough to ensure that cardiorespiratory depression does not recur.

Reversal of neuromuscular blockade

Specific antagonists should be administered for reversal of residual neuromuscular blockade as indicated.

PACU = postanesthesia care unit

Antagonism of the Effects of Sedatives, Analgesics, and Neuromuscular Blocking Agents

Antagonism of Benzodiazepines

Recommendations: Specific antagonists should be available whenever benzodiazepines are administered. Flumazenil should not be used routinely, but may be administered to antagonize respiratory depression and sedation in selected patients. After pharmacologic antagonism, patients should be observed long enough to ensure that cardiorespiratory depression does not recur.

Antagonism of Opioids

Recommendations: Specific antagonists should be available whenever opioids are administered. Opioid antagonists (e.g., naloxone) should not be used routinely but may be administered to antagonize respiratory depression in selected patients. After pharmacologic antagonism, patients should be observed long enough to ensure that cardiorespiratory depression does not recur. The Task Force reminds practitioners that acute antagonism of the effects of opioids may result in pain, hypertension, tachycardia, or pulmonary edema.

Reversal of Neuromuscular Blockade

Recommendations: Specific antagonists should be administered for reversal of residual neuromuscular blockade when indicated.

Protocol for Discharge

Requiring That Patients Urinate before Discharge

Recommendations: The routine requirement for urination before discharge should not be part of a discharge protocol and may only be necessary for selected patients (See tables below titled "Summary of Recommendations for Discharge" and "Summary of Recovery and Discharge Criteria").

Requiring That Patients Drink Clear Fluids without Vomiting before Discharge

Recommendations: The requirement of drinking clear fluids should not be part of a discharge protocol and may only be necessary for selected patients, determined on a case-by-case basis (e.g., diabetic patients) (See tables below titled "Summary of Recommendations for Discharge" and "Summary of Recovery and Discharge Criteria").

Requiring That Patients Have a Responsible Individual to Accompany Them Home after Discharge

Recommendations: As part of a recovery room discharge protocol, all patients should be required to have a responsible individual accompany them home (See tables below titled "Summary of Recommendations for Discharge" and "Summary of Recovery and Discharge Criteria").

Requiring a Minimum Mandatory Stay in Recovery

Recommendations: Patients should be observed until they are no longer at increased risk for cardiorespiratory depression. A mandatory minimum stay should not be required. Discharge criteria should be designed to minimize the risk of central nervous system or cardiorespiratory depression after discharge (See tables below titled "Summary of Recommendations for Discharge" and "Summary of Recovery and Discharge Criteria").

Summary of Recommendations for Discharge

Requiring that patients urinate before discharge The requirement for urination before discharge should not be part of a routine discharge protocol and may only be necessary for selected patients. Requiring that patients drink clear fluids without vomiting before discharge The demonstrated ability to drink and retain clear fluids should not be part of a routine discharge protocol but may be appropriate for selected patients. Requiring that patients have a responsible individual accompany them home As part of a discharge protocol, patients should routinely be required to have a responsible individual accompany them home. Requiring a minimum mandatory stay in recovery A mandatory minimum stay should not be required. Patients should be observed until they are no longer at increased risk for cardiorespiratory depression. Discharge criteria should be designed to minimize the risk of central nervous system or cardiorespiratory depression after discharge.

Summary of Recovery and Discharge Criteria

General principles Medical supervision of recovery and discharge is the responsibility of the supervising practitioner. The recovery area should be equipped with appropriate monitoring and resuscitation equipment. Patients should be monitored until appropriate discharge criteria are satisfied. Level of consciousness, vital signs, and oxygenation (when indicated) should be recorded at regular intervals. A nurse or other individual trained to monitor patients and recognize complications should be in attendance until discharge criteria are fulfilled.

An individual capable of managing complications should be immediately available until discharge criteria are fulfilled.

Guidelines for discharge

Patients should be alert and oriented. Patients whose mental status was initially abnormal should have returned to their baseline.

Vital signs should be stable and within acceptable limits.

Discharge should occur after patients have met specified criteria. Use of scoring systems may assist in documentation of fitness for discharge.

Outpatients should be discharged to a responsible adult who will accompany them home and be able to report any postprocedure complications.

Outpatients should be provided with written instructions regarding postprocedure diet, medications, activities, and a phone number to be called in case of emergency.

Each patient care facility should develop suitable recovery and discharge criteria. The table lists some of the basic principles that might be incorporated in these criteria.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Scientific evidence was derived from multiple sources, including aggregated research literature (with meta-analyses when appropriate), surveys, open presentations, and other consensus-oriented activities. The findings of the literature analyses were supplemented by the opinions of Task Force members and surveys of the opinions of a panel of consultants.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improvement in postanesthetic care outcomes and optimization of patient safety
- Improvements in patient comfort and satisfaction

POTENTIAL HARMS

Adverse effects of pharmacological interventions

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Practice guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints.
- Practice guidelines are not intended as standards or absolute requirements. The use of practice guidelines cannot guarantee any specific outcome. Practice guidelines are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Society of Anesthesiologists Task Force on Postanesthetic Care. Practice guidelines for postanesthetic care: a report by the American Society of Anesthesiologists Task Force on Postanesthetic Care. Anesthesiology 2002 Mar;96(3):742-52. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Mar

GUIDELINE DEVELOPER(S)

American Society of Anesthesiologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society of Anesthesiologists

GUIDELINE COMMITTEE

Task Force on Postanesthetic Care

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Jeffrey H. Silverstein, MD (Chair), New York, New York; Jeffrey L. Apfelbaum, MD, Northbrook, Illinois; Jared C. Barlow, MD, Grand Island, New York; Frances F. Chung, MD, Toronto, Ontario; Richard T. Connis, PhD, Woodinville, Washington; Ralph B. Fillmore, MD, Dothan, Alabama; Sean E. Hunt, MD, Manchester, New Hampshire; Thomas A. Joas, MD, San Diego, California; David G. Nickinovich, PhD, Bellevue, Washington; Mark S. Schreiner, MD, Philadelphia, Pennsylvania

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Society for Anesthesiologists Web site.

Print copies: Available from the American Society for Anesthesiologists, 520 North Northwest Highway, Park Ridge, IL 60068-2573.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 13, 2005. The information was verified by the guideline developer on July 20, 2005.

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